SECTION THREE RESIDENTIAL TREATMENT

I. CORE STANDARDS FOR RESIDENTIAL TREATMENT and LEVEL II RESIDENTIAL TREATMENT

A. Scope of Services

Level II Residential Treatment is designed to meet the needs of children who are unable to live at home or in a Resource Family and require temporary care in a group or residential setting. The residential treatment program provides structure, counseling, behavioral intervention and other services identified in a child's permanency plan for children with moderate clinical needs. Children in this program type attend public school in the community.

Goals/discharge criteria for Children in Level II Residential Treatment:
Permanency through reunification, kinship care, adoption, or guardianship.

B. Admission/Clinical Criteria

1. The service is available to children—regardless of adjudication type—whose relationship with their families or whose family situation, level of development, and social or emotional problems are such that services in a family setting would not meet the child's treatment needs due to supervision, intervention, and/or structure needs.
2. Programs are designed for youth in need of twenty-four hour care and integrated planning addressing behavioral, emotional, or family problems and the need for progressive reintegration into family and community living. Children in Level II Residential Treatment remain involved in community based schools and participate in community based recreational activities with appropriate supervision.
3. Children may have a history of truancy but are able to attend public school with liaison and support services provided by the agency.
4. Children may have a history of impulsive behaviors, alcohol and/or drug misuse, aggression, and moderate mental health treatment and intervention needs. Children may have patterns of runaway episodes, have difficulty maintaining self-control, display poor social skills, and/or have difficulty accepting authority.
5. Children in this level of care have behaviors that can be treated in a non-secure setting, with adult supervision and intervention.
6. Children may have completed higher levels or intensity of care and determined appropriate for a move towards permanency.
7. Children in this level of care do not meet the criteria for higher levels of care.
8. Children in this level of care may require outpatient therapy, medication, and medication management which will be coordinated by the agency and integrated into treatment planning.
9. Children with developmental delays are reviewed on a case-by-case basis to determine if the child could be appropriately served by the agency. A diagnosis of mental retardation is not used as a basis to refuse admission to a child when the child's behavioral issues fall within the Level II guidelines.
10. The agency may not reject children who fall within the scope of services.
11. Children who are ineligible for this level of care are those who have need of acute psychiatric

hospitalization and/or require incarceration for major acts of violence or aggression within the past six (6) months. Those who pose a significant risk to the community are not appropriate for this level of care.

C. Personnel Ratio

1. Adequate care and supervision is provided at all times to assure that children are safe and that their needs are met, in accordance with their developmental level, age, and emotional or behavioral problems, and include
   a. at least one on duty child care worker providing continuous supervision for each living group of eight children or youth; 1:8
   b. higher adult/child ratios during periods of greater activity;
   c. availability of additional or back up direct care staff for emergency situations or to meet special needs presented by the children in care; and
   d. overnight awake staff at 1:8 ratio.
2. No more than five (5) experienced providers of case coordination or casework service report to one (1) supervisor.
3. The case loads for personnel providing case coordination or casework services do not exceed fifteen (15) residents, and may be adjusted according to current case responsibilities.
4. No more than seven (7) experienced direct care staff members report to one supervisor and the ratio is reduced to one to five when the workers are inexperienced.
5. The agency has the services of a licensed physician available on at least an on-call basis to provide and/or supervise medical care.

D. Individualized Treatment Plans

The agency will meet the standards outlined in Chapter One, Section III.U.

E. Service Overview

1. The agency shall meet the standards set forth in Chapter One, Core Standards.
2. The service provides group living experiences and a program of specialized services for each child accepted for care.

F. Service Components within the per diem

1. Planning for stability and permanence in the care and provision of services to each child includes:
   a. engagement of the child's parents in the placement and planning process,
   b. ongoing efforts to obtain parental participation in services,
   c. assistance to the child's parents in resolving problems that necessitated the child's removal,
   d. retention of the maximum feasible family involvement in the decision-making and maintenance of contact between the family and child (unless clearly contraindicated by the Child and Family Team), and
   e. assistance with recruitment of an adoptive or a long-term resource family, if indicated by the child's permanency plan.
2. Depending on the needs of the children in care, the services of qualified professionals in various mental health disciplines, consultants and specialists in dentistry, medicine, nursing, education, speech, occupational and physical therapy, recreation, dietetics, and religion are available among the agency's personnel or through cooperative arrangements, and are integrated with the core

services of the agency to provide a comprehensive program. Basic services include but are not limited to

a. Educational liaison;
b. Coordination of individual, group and/or family therapy by an appropriately licensed or credentialed provider;
c. Individual, group and/or family counseling provided by person with a bachelor's degree and at least one year of experience supervised by master level personnel;
d. Recreational programming;
e. Structured behavioral assessment, management and intervention system;
f. Three (3) hours daily of documented, structured individual or group treatment activities and/or process groups;
g. Individualized intervention services identified as needed to meet the child's treatment goals;
h. Alcohol and drug intervention;
i. Independent living training and skills building;
j. Coordination of outpatient alcohol and drug treatment;
k. Case management and coordination.

G. Education of the Child/Youth

1. There is a presumption that children in Level II care will attend public school. Educational services must be met through the most appropriate setting to meet the educational and treatment needs of the child. This includes both general and special education programs. Programs must operate or subcontract a self-contained educational service, if there is an exception approved for the child to attend a self-contained educational program through a Child and Family Team meeting, as outlined in Educational services policy. Providers of on-site educational programs must be approved as providers of this type of service by the Department of Children's Services. Any child receiving educational services in a self-contained (in-house) school setting must be approved for these services through a Child and Family Team review, as outlined in Department of Children's Services educational policy.
2. Agencies will appoint a local staff member to act as "school liaison." The agency school liaison will develop a collaborative relationship with the public school system to assist children/youth in maintaining positive and successful school experiences. The school liaison must be available during the school day to respond to public school inquiries.
3. Former school records are obtained promptly upon admission and up to date records are provided to the new school when the child is referred elsewhere.
4. Personnel from the residential center facilitate school transfers and provide consultation as needed to the professionals in off-campus educational settings.
5. Agency provides tutoring, academic enrichment or other services needed for the child to successfully achieve educational goals.

H. Monitoring Progress

1. Level II Residential Programs examine the need for and appropriateness of service for clients through a Child and Family Team Meeting, at least quarterly or as determined by the team, reviewing

a. continued out-of-home care,

b. efforts for family reunification, and

c. the adequacy of efforts to preserve and continue the parent/child relationship when possible and in the child's interest.

2. The agency must submit a Monthly Progress Report to the DCS FSW, Resource Management Unit, Involved Adult, if any, the Advocacy Contractor, the SAT Coordinator and TennCare Advocacy (if in continuum) .
3. The agency must participate in any other reviews deemed necessary by DCS or the courts.
4. The agency must participate fully with Program Accountability and Review monitoring.
5. The agency will respond and provide immediately required documentation as requested by TennCare Consumer Advocate (TCCA) or Tennessee Alliance for Legal Services (TALS).

I. Utilization Review

The agency will meet the standards outlined in Section One, Section I. F.

J. Discharge Criteria

Children/youth will be discharged in compliance with CFTM protocol.

II. RESIDENTIAL TREATMENT LEVEL III

A. Scope of Services

Level III Residential Treatment provides a therapeutic treatment program in a 24-hour-a-day residential facility for children and youth with severe emotional and/or psychological treatment needs. Through an individualized treatment plan, the agency provides intensive mental health treatment, including psychiatric services when indicated, and educational services.

B. Admission/Clinical Criteria

1. The DCS Family services worker prepares the Referral Packet, which will contain the rationale for placement as well as all available current, historical, familial, psychosocial and related clinical data (e.g., measures of psychopathology, assessments of strengths and needs) regarding a youth.
2. The following criteria must be met for admission to a Level III residential program:
    a. The youth has a significantly severe mental health disorder (DSM-IV-TR) and is impaired in social, educational, familial, and occupational functioning. This level of functioning is not due exclusively to mental retardation, organic dysfunction, or developmental disabilities. This disorder is amenable to “psychiatric treatment” and requires mental health treatment that cannot be successfully provided at a lower level of care. The youth needs psychiatric consultation and access to physician services as well as daily supportive guidance toward stabilization.
    b. The youth is unable to adequately care for physical needs without external support that is beyond the capacity/capabilities of the family and/or other non-inpatient community support system representatives to provide. This inability represents harm to self or others (e.g., reckless self-endangerment) and is due to psychiatric disorder *not* developmental, social, cognitive, or specific medical limitations.
    c. The youth’s current living environment, family setting, extended community do not provide the support and access to therapeutic services necessary to maintain stability or maximize effective daily functioning and/or the youth has not been successful in lower levels of treatment efforts (i.e., has failed to maintain or sustain adequately).
    d. The youth cannot achieve successful adaptation for the purpose of stabilization *at this time* without significant structure and supportive residential guidance that can only be provided through twenty-four (24) hour intervention and supervision in a highly structured environment.
    e. The youth meets the age, cognitive capacity, adaptive functioning level and/or developmental level requirements necessary for minimal acceptance in the specific setting.
    f. The youth does not require medical substance abuse treatment as the primary need, does not have contraindicated medical conditions that are primary and supersede the psychiatric symptoms, and/or has not been adjudicated as a sexual perpetrator who requires specialized treatment services in a unique setting.
3. Children have been identified as having moderate to severe mental health treatment needs.
4. Children may be of any adjudication type.
5. Children may pose a high risk for elopement, instability in behavior and mental health status, or occasionally experience acute episodes. These youth also experience persistent maladjustment of peer and other social relationships or other influencing systems, which interfere with learning

and social environments.

6. Children with primary diagnosis of mental retardation are evaluated on a case-by-case basis. Children with an IQ lower than 55 or who have adaptive functioning indicating moderate to severe mental retardation are not appropriate unless the agency is licensed for this service type.
7. Children who are acutely suicidal or homicidal or who have psychoses not controlled with medication will be referred to inpatient psychiatric treatment through specialized crisis services. They do not have records of major acts of violence or aggression which have required incarceration within the past six (6) months.
8. The provider agency may not reject children deemed appropriate for the scope of service.

C. Personnel Ratio

1. The service has qualified personnel who can meet the developmental and therapeutic needs of all children accepted for care and services
2. Adequate care and supervision are provided at all times to assure that children are safe and that their needs are met in accordance with their developmental level, age, and emotional or behavioral problems. Residential Level 3—1.5 during the day and 1.8 overnight awake staff
3. The provider agency has available the services of a licensed physician on at least an on-call basis to provide and/or supervise medical care on a 24-hour basis. If this person is not a psychiatrist, then the facility must arrange for the services of a psychiatrist for regular, emergency and consultative services.

D. Individualized Treatment Plan

1. An initial treatment plan will be developed within three (3) days of admission. A more formalized treatment plan must be developed within seven days of admission after any needed testing or consultation has occurred.
2. The child's treatment plan will include a specific strengths-based family integration/reintegration treatment plan. It will also include guidelines for family participation while the child is at the facility. These family participant guidelines will contain frequency of family visits, whether visits are supervised, and location of visits. The agency will work with the facility to address transportation and communication barriers. Family counseling and family visits shall not be contingent on the child's behavior.
3. The treatment plan also will include all goals for educational issues, mental health needs (including therapy and psychiatric medications), substance use issues, physical/medical concerns, and family participation in treatment.
4. The individual treatment plan should consider discharge goals and estimated length of stay. Discharge planning should begin at admission and be an ongoing process.
5. The treatment plan will be updated at least quarterly.

E. Service Components Provided within the per diem

1. Service Components Required of All Level III Residential Programs
   a. Twenty-four (24) hour awake staff;
   b. Comprehensive assessment of the child to include coordination of EPSDT screening and recommended follow-up services, updated Family Functional Assessment, academic history, and psychological evaluation if needed;
   c. Behavior management system emphasizing positive reinforcements;
   d. Development of Individualized Crisis Management Plan if warranted by youth behavior;

e. Social skills training;

f. Activity therapy;

g. Daily living skills;

h. Daily group counseling within the context of the milieu;

i. Group therapy conducted by an appropriately credentialed staff at a frequency determined by the treatment team

j. Individual therapy by an appropriately credentialed staff at least weekly;

k. Family therapy

A Family of Care—biological, relative, or foster—will be identified by the DCS FSW, regional resource manager and Level III private provider staff as soon as possible following admission to the facility if the youth does not already have a family identified. Ideally, this is the family to whom the child will go after discharge. Either in person or by telephone, the assigned therapist will meet with the family of care and the DCS FSW **within the first week of admission.** Family therapy will be conducted at least weekly or as advised by the CFTM or valid reasons will be identified why such a plan for family involvement is not appropriate.

l. Psychiatric evaluation or consultation upon admission and ongoing psychiatric management as needed

m. Attending physician must document treatment and progress resulting from a face-to-face contact at least one time per month.

n. TN Department of Education and DCS approved educational program in compliance with all necessary educational requirements including special education services when applicable

o. Nationally recognized crisis intervention program for the use of seclusion, restraint and restrictive interventions.

2. Plans for stability and permanence in the care and provision of services to each child include assistance with recruitment of an adoptive or a long-term support family, if indicated by the child's permanency plan.

F. Education of the Child/Youth

1. There is a presumption that children who meet the criteria for placement in a Level III Residential Treatment programs require intervention and intensive clinical treatment twenty-four (24) hours per day. Due to this high level of intervention and treatment, educational services for these children must be provided in an in-house school.
2. Prior to the child's thirtieth (30th) day in the RTC, a CFTM must be convened in order to determine the child/youth's appropriateness for continuation in the RTC. The CFTM should include a local education representative and/or attorney.
3. If the CFT consensus indicates that the child/youth continues to need treatment at the RTC, the child must continue to attend the in-house school. A review and target date for completion of treatment will be established.
4. If the CFT consensus indicates that the child/youth no longer requires treatment in an RTC, then the team will set a target date for enrollment and transition to public school based on the best interest of the child.
5. The residential center has an on campus, in-house educational program, approved by the Tennessee Department of Education and the Department of Children Services.
6. Former school records are obtained promptly upon admission and up to date records are provided

to the new school when the child is referred elsewhere.

7. The resident who is assessed to be ready for placement in an off-campus school setting or to be mainstreamed in a regular classroom is placed in accord with the goals and timetables of their individual educational plan.
8. Agency provides tutoring, academic enrichment or other services needed for the child to successfully achieve educational goals

G. Utilization Review

The agency will meet the standards outlined in Chapter One, Section I.F. Utilization review occurs at least every 30 days.

H. Discharge Criteria

Children/youth will be discharged according to decision of CFTM and using CFTM protocol.

III. LEVEL IV RESIDENTIAL TREATMENT

A. Scope of Services

1. Level IV is hospital-based residential care, which is a physician-directed level of care focused on establishing the behavioral and emotional prerequisites for functioning in the most appropriate, non-hospital environments.
2. It is a transitional level of care that a child may enter as a move towards permanency from an acute admission or as a temporary admission from a lower level of care for the purpose of emotional and/or behavioral stabilization.
3. The child's treatment team under the leadership of the physician makes decisions regarding which clinical issues are addressed on the plan of care, the sequence in which they are addressed and discharge recommendations.
4. The use of seclusion or restraint in Level IV programs shall be directed by a licensed independent practitioner and must be in compliance with applicable statutory, Department of Children's Services, licensure, CMS and accreditation requirements.
5. The DCS Regional Well-being Unit Psychologist must approve all admissions of children in custody to a Level IV program.

B. Admission/Clinical Criteria

1. Level IV programs operated under terms of this agreement shall be designed to serve children in the custody of the Department of Children's Services (DCS) who do not meet criteria for involuntary acute psychiatric hospitalization but who continue to require specialized mental health services, which are highly structured, therapeutically intensive, and provided within a psychiatric facility.
2. The DCS FSW prepares the Referral Packet containing rationale for placement and historical data regarding a youth. The psychologist will first review all available historical, familial, psychosocial, and related clinical data (e.g., measures of psychopathology, assessment of strengths and needs) that is presented as justifying the request for admission in a secure, intense, and controlled residential treatment center at a Level IV status at this time.
3. The DCS Regional Well-being Unit Psychologist considers whether the following medical necessity criteria are met.
    a. The youth has a significantly severe mental health disorder (DSM-IV-TR) and is markedly impaired in social, educational, familial, and occupational functioning. This level of functioning is not due exclusively to mental retardation, organic dysfunction, or developmental disabilities. This disorder is amenable to "active psychiatric treatment" and requires physician-directed care that cannot be successfully provided at a lower level of care. The youth cannot be medically stable in a most appropriate setting, requires 24-hour nursing staff on site, minimal of weekly psychiatric face-to-face consultation, and daily supportive guidance toward short-term stabilization status.
    b. The youth is unable to adequately care for physical needs without external support that is beyond the capacity/capabilities of the family and/or other non-inpatient community support system representatives to provide. This inability represents harm to self or others (e.g., reckless self-endangerment) and is due to psychiatric disorder *not* developmental, social, cognitive, or specific medical limitations.
    c. The youth's current living environment, family setting, extended community do not provide the

support and access to therapeutic services necessary to maintain stability or maximize effective daily functioning and/or the youth has not been successful in lower levels of treatment efforts (i.e., has failed to maintain or sustain adequately).

d. The youth cannot achieve successful adaptation for the purpose of short-term stabilization *at this time* without significant structure and supportive inpatient guidance that can only be provided through twenty-four (24) hour per day, seven (7) day per week regimen.

e. The youth meets the age, cognitive capacity, adaptive functioning level and/or developmental level requirements necessary for minimal acceptance in the specific setting.

f. The youth does not require medical substance abuse treatment as the primary need, does not have contraindicated medical conditions that are primary and supersede the psychiatric symptoms, and/or has not been adjudicated as a sexual perpetrator who requires specialized treatment services in a unique setting.

C. Admissions Process

1. All referrals for level IV services for children in custody will be made to the Regional Well-being Unit Psychologist. The Regional Well-being Unit Psychologist will conduct a case review including, whenever possible, face-to-face interviews with the child and his or her caregiver to determine the appropriateness of Level IV services.
2. The psychologist will consult with the DCS FSW and resource manager about the appropriateness of Level IV services.
3. The psychologist, FSW and resource manager will jointly discuss the case with the Level IV provider and decide if the child is appropriate for a Level IV program. If deemed appropriate, an admission will be accomplished.

D. Personnel Ratio

1. The agency provides a physician-directed program and has available the services of a licensed physician on a 24-hour basis.
2. The agency needs to comply with DMHDD licensing regulations (for their type of licensure) regarding ratio of children to staff.
3. Depending on the needs of the children in care, the services of qualified and appropriately credentialed professionals will be available among the agency's personnel or through cooperative arrangements.
4. Residential Level 4—Provide a direct-care staffing level of at least 2 direct-care staff members on duty/on site per ward per shift with at least one (1) nurse per building per shift. Supervision by a Registered Nurse must be provided at the facility on a 24-hour per day basis.

E. Individualized Treatment Plan

1. An initial treatment plan will be developed within three (3) days of admission and reviewed with the regional psychologist. A more formalized treatment plan must be developed within seven days of admission after testing and consultation.
2. The regional psychologist will be present, in person or by telephone, at the child's initial treatment team meeting. If the regional psychologist cannot be present upon notification from the provider, he/she will be provided the opportunity for input prior to the initial treatment team meeting.
3. The child's treatment plan will include a specific strengths-based family integration/reintegration treatment plan. It will also include guidelines for family participation while the child is at the facility. These family participant guidelines will contain frequency of family visits, whether visits are

supervised, and location of visitations. DCS will work with the provider to address transportation and communication barriers. Family counseling and family visits shall not be contingent on the child's behavior.

4. The treatment plan also will include all goals for educational issues, mental health needs (including therapy and psychiatric medications), substance use issues, physical/medical concerns, and family work.
5. Within three (3) days of admission, a preliminary discharge plan will be drawn up through collaboration between the regional psychologist and the treatment team of the Level IV agency. This discharge plan will contain an estimate of the length of stay and discharge goals.

F. Service Components Provided within the per diem

1. Service components required of all Level IV programs:
   a. Twenty-four (24) hour awake staff;
   b. Comprehensive assessment of the child, if not current, to include coordination of EPSDT screening and recommended follow-up services, updated Family Functional Assessment, academic history, and psychological evaluation if needed;
   c. Behavior management system emphasizing positive reinforcements;
   d. Development of Individualized Crisis Management Plan if warranted by youth behavior;
   e. Social skills training;
   f. Activity therapy;
   g. Daily living skills;
   h. Daily group counseling within the context of the milieu;
   i. Group therapy conducted by an appropriately credentialed staff at a frequency determined by the treatment team. The treatment team is encouraged to include the regional psychologist in the treatment planning;
   j. Individual therapy by an appropriately credentialed staff at least twice weekly;
   k. Family therapy

      A Family of Care—biological, relative, or foster—will be identified by the family services worker, regional resource manager and Level IV staff as soon as possible following admission to the facility if the youth does not already have a family identified. This the family to whom the child will return after discharge. Either in person or by telephone, the assigned therapist will meet with the Family of the Care and DCS FSW within the first three (3) days of admission and at least twice weekly thereafter. Family therapy will be conducted by an appropriately credentialed professional at a frequency determined by the treatment team but no less than once a week.
   l. Psychiatric evaluation by the treating psychiatrist within three (3) days of admission, and at least weekly contact with the psychiatrist on an ongoing basis;
   m. Tennessee Department of Education and DCS approved educational program in compliance with all necessary educational requirements including special education services when applicable;
   n. Nationally recognized crisis intervention program for the use of seclusion, restraint and restrictive interventions; and
   o. Specialized treatment needs identified by the treatment team or CFT that may not be generally available but are critical to the overall treatment, stability and success of the youth.

G. Education of the Child/Youth

1. There is a presumption that children who meet the criteria for placement in hospital-based residential program require intervention and intensive clinical treatment twenty-four (24) hours per day. Due to this high level of intervention and treatment, educational services for these children must be provided in an in-house school.
2. Educational approvals are through the Tennessee Department of Education and Department of Children's Services, Education Division.
3. Prior to the child's thirtieth (30th) day in the Level IV program, a CFTM must be convened in order to determine the child/youth's appropriateness for continuation in the program. The Child and Family Team should include a local education representative and education representative and/or attorney.
4. If the CFT consensus indicates that the child/youth continues to need treatment at Level IV, the child must continue to attend the in-house school. A review and target date for completion of treatment will be established.
5. If the CFT consensus indicates that the child/youth no longer requires treatment at Level IV, then the team will set a target date for enrollment and transition to public school based on the best interest of the child.
6. The residential center has an on campus, in-house educational program, approved by the Tennessee Department of Education and the Department of Children Services.
7. Former school records are obtained promptly upon admission and up to date records are provided to the new school when the child is referred elsewhere.
8. The resident who is assessed to be ready for placement in an off campus school setting or to be mainstreamed in a regular classroom is placed in accord with the goals and timetables of their individual educational plan.
9. Agency provides tutoring, academic enrichment or other services needed for the child to successfully achieve educational competency.

H. Monitoring Progress

1. Progress reports will be forwarded to the DCS FSW, regional resource manager and regional psychologist at 14-day intervals. The agency will provide any additional information needed for the regional psychologist to review the child's progress toward treatment goals and discharge goals at these 14-day intervals. For this review, the agency will coordinate with the regional psychologist to allow for the psychologist to participate in person or by telephone, in the child's treatment review nearest to the 14-day interval.
2. The agency will give the regional psychologist and the regional nurses access to information about psychotropic medication and seclusion and restraint instances. Level IV staff may be asked to consult with regional well-being unit staff about these issues.

I. Discharge Planning and Discharge Criteria

1. A preliminary discharge plan with discharge goals, projected length of stay, and tentative aftercare plan will be formulated and shared with the DCS regional psychologist, educational specialist, family services worker, and placement specialist.
2. A youth is ready for discharge when he/she no longer meets the admission criteria (outlined above) and sufficient aftercare services (e.g., mental health, education, family, medical/physical) have been arranged to allow for a smooth transition toward permanency.